POWER MOBILITY DEVICES (PMDs) AND CUSTOM MANUAL WHEELCHAIRS

(Physician Also To Sign PT/OT Evaluation – Information Must be Complete & Legible)

Patient's Name:_____RIN:_____Birth Date:_____
Physician's Name (Print): _____ State License No._____
Physician's Phone No. [_____]_____Face-to-Face Evaluation Date:_____/_____/_____

The Patient Needs: [ ] Power Wheelchair [ ] Power Scooter [ ] Custom Manual Wheelchair

ATTACH ORDER ON SEPARATE SHEET

- ***Medical Necessity Must Be Documented For Each Item Ordered (Brief Narrative Description)***
- **[ ]** ***Check if Delegated To Evaluating Physiatrist or Physical/Occupational Therapist***

Patient's Diagnoses: (ICD9 Codes Optional) – Date Onset If Known: _____
_____

Describe Patient's Disabilities That Require Mobility Equipment: (*Use Quantitative Terms To Describe Effects on Mobility)*

NEURO/MUSCULO/SKELETAL: _____
_____
Date Onset_____[ ] Slowly Progressive [ ] Rapidly Progressive [ ] Stable **Requires: [ ] PMD [ ] Cust. Man.W.C.**
CARDIOVASCULAR/PULMONARY: _____
_____
Date Onset _____ [ ] Slowly Progressive [ ] Rapidly Progressive [ ] Stable **Requires:[ ] PMD [ ] Cust. Man.W.C.**
WEAKNESS: (State Etiology)_____
_____
Date Onset _____ [ ] Slowly Progressive [ ] Rapidly Progressive [ ] Stable **Requires:[ ] PMD [ ] Cust. Man.W.C.**
OTHER:_____
Date Onset_____[ ] Slowly Progressive [ ] Rapidly Progressive [ ] Stable **Requires: [ ] PMD [ ] Cust.Man.W.C.**

Patient's Potential For Improvement: [ ] None Expected [ ] Good Expected In: [ ] Months.

Has Patient Had Surgery Recently Or Is It Being Planned? [ ] No [ ] Yes If Yes: What, When,_____
What Is Expected Effect On Patient's Mobility & When Is Improvement Expected**: _____**
_____

Patient's Current Weight:_____ Lbs- Weight 1 year ago _____Lbs - Weight 2 years ago _____Lbs
Describe Growth Of Pediatric Patient Past 2- 5 Years - (Ht., Wt., & Seating Measurements - dates)
_____

The Patient Can Operate The Ordered Equipment Safely & Responsibly: [ ] Yes [ ] No
Patient Is Restricted To Operating In Home Environment Only: [ ] Yes [ ] No
Comment: _____

If A Power Wheelchair Is Ordered, Could A Power Scooter Serve The Patient's Needs? If Not, Why? _____

I the undersigned certify that the above information is true, that this patient requires the ordered equipment/accessories because of his/her documented medical condition(s), that this patient can safely & responsibly operate the equipment, and that the use of the equipment is not for the patient's convenience but is medically necessary for mobility.
I also certify with my signature on their documents that I have reviewed all information provided by the evaluating Physiatrist or Physical/Occupational Therapist and concur with or have noted my disagreements with their findings.

_____
Ordering Physician's Signature **Date**